Patient Responsibility & Payer Pre-Billing Requirement Impacting Your Bottom Line?
Engage Physicians and Patients with Patient Access Solutions & Analytics To Improve Revenue

Quadax Benefactor Session
Tuesday, April 30
8:30AM – 9:20AM
Presenters

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Who We Are

For over 45 years, Quadax has delivered revenue cycle optimization and business intelligence solutions for hospitals, physician groups, medical facilities and more.

We empower clients to drive the costs out of healthcare revenue cycle.
Over 45 Years of Experience

KLAS CATEGORY LEADER
CLAIMS MANAGEMENT
2018

KLAS CATEGORY LEADER
CLAIMS MANAGEMENT
2019

By the Numbers

365,000+ Providers

4,000+ Payers

50 States Processing Claims

165M+ EDI Transactions

$32B Provider Payments

52% Acute Care Claims

225+ Hospitals/Health Systems

95%+ Client Retention

42 States With Existing Clients
Patient Access by Quadax

**KEY LEARNING OUTCOMES**

- Understand the impact of market trends in the lab space
- Discover practical solutions integrated at the point-of-decision to manage the challenges associated with:
  - Incomplete or inaccurate patient information
  - Increased patient financial responsibility
  - Unique payer requirements
- Review the value of integrated solutions from the front-end to the back-end of the revenue cycle
Market Trends & Challenges

**9 in 10**
Healthcare consumers would like pricing information in advance of care

**7 in 10**
Patients are more likely to use a provider or service that estimates out-of-pocket expenses upfront

High deductible health plans continue to rise – in 2019 expected to be over 60% of total employee plans

Source: Accenture, “The Demographics of Price Transparency,” 2018
Market Challenge: Finding Accurate Data and Coverage

Estimated that over 35% of claim denials are due to inaccurate or missing data

- Laboratories are more likely to receive incomplete, incorrect, or outdated insurance information
- Staff is forced to track down patient coverage, or abandon it as self-pay which decreases patient and provider satisfaction
- Back-and-forth between patients, provider, and laboratories causes mutual frustration and delay
Market Challenge: Adapting to clinical requirements

**Managing Clinical Requirements**

- Steady increase in prior authorization and medical necessity requirements for complex testing
- Traditionally a very manual and disconnected process
- Clinical requirements change often, requiring a significant amount of training and education for providers and staff
The Potential: Patient Access in a National Lab
The Potential: Patient Access in a National Lab

Number of Labs: 3
Accessions: 5,000 per day (100,000 per month)
Average Allowable: $650 per test

Additional information:
• Physician Ordering portal built on SalesForce
• Without integration, manual Patient Access process was time consuming and still resulted in high number of encounters abandoned as self-pay
• Even with manual processes, 35% of their accessions had missing or invalid patient/insurance information
• Increasing number of denials due to missing prior authorization/statement of medical necessity
An inefficient process with significant back-and-forth with patient and doctor.

High number of abandoned encounters incorrectly converted to self-pay
The Opportunity: API-driven Interoperability

API utilization in healthcare is expected to increase by over 40% in next 5 years.

APIs are:

• Cost-effective, interoperable, secure, and scalable
• Flexible enough to be used for customized workflows or interfaces

The Solution: API Packages

API PACKAGES
Integrated at point of decision (patient, physician, LIS)

Advanced Eligibility
- Eligibility
- Patient ID Verification
- Insurance Discovery
- Auto plan selection

Clinical Clearance
- Prior Auth Assessment
- Medical Necessity Verification

Financial Clearance
- Normalized Patient Benefits
- Out-of-Pocket Estimator

Predictive Analytics
- Denial Prediction
- Common Denials
- Expected Reimbursement
- Tiered Scoring (I, II, III)
Flexible Delivery Models Adapt to Your Needs

You

UI

API

Hybrid

Us
Goal State: Patient Access Flow in a National Lab

Services integrated at point of decision (flexibility: patient, physician, LIS)
Eligibility and coverage at order entry

Patient’s insurance from order entry is used to create a real-time eligibility response via API.

Presents eligibility and errors to a portal user early – before order is even completed.
The Solution – Demographics and Insurance Discovery

**Insurance Discovery**

When data or coverage was unknown or invalid, insurance discovery found coverage, in real-time – before an order was even completed.

Insurance discovery reduces number of claims rejected for missing/bad eligibility – from 35% to 21%.

Before:
- Clean Eligibility: 65%
- Rejected – Bad info: 35%

After:
- Clean Eligibility: 83%
- Rejected / Bad Info: 21%

40% reduction in self-pay and uncompensated accounts
Auto-Plan Selection and Prior Authorization

1. Specific Insurance auto assigned
2. Lookup Associated Pre-Claim clinical requirements, e.g. prior auth or medical necessity
3. Helps drive workflow and denial avoidance

26% Faster payment using prior auth to stay informed of payer clinical programs

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<tbody>
<tr>
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<tr>
<td>Plan</td>
<td>PPO Choice Plus</td>
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<tr>
<td>Pre-Claim Requirements</td>
<td>Prior Authorization Required Statement of Medical Necessity</td>
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The Solution – Out-of-Pocket Estimator

Patient Out-of-Pocket Estimation

- Benefits derived from eligibility
- Cost derived from expected amounts or average allowable by payer/plan contract

**ESTIMATE WORKSHEET**

<table>
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<th>Patient Name: Jeffrey Smith</th>
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<tr>
<td>Service Date: 4/21/2019</td>
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<td>Account #: 889900A</td>
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<td>Policy Number: XXX94082222</td>
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<tr>
<td>Group Number: JBT09899</td>
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<td>Insurance: Anthem</td>
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**Laboratory**

- The code(s) this estimate is based on:
  - CODE: 81163 BRCA2 SEQUENCING TEST (1 EACH UNIT)

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The Solution – Predictive Analytics
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The Benefit: Optimized Patient Access Workflow

$9.1\,\text{MM}$ in additional reimbursements per month due to insurance discovery

$2.6\,\text{MM}$ in additional reimbursements due to denial avoidance

5 FTEs diverted to higher value tasks due to operational savings

$14\%$ (decrease in bad info denials) 
$\times$ 100,000 tests 
$\times$ $650$ average reimbursable

$4\%$ (decrease in auth/med nec denials) 
$\times$ 100,000 tests 
$\times$ $650$ average reimbursable

this is based on assumption that roughly only 20% of bad info accounts were handled by team
Thank you.